



2009 H1N1 (Swine Flu) Influenza Vaccine Consent Form FluMist

Harford County Health Department

Name (Last, First):

Address:

City: State: Zip:

Phone: - - Other Phone: - -

Date of Birth: / / Age: Gender: Male Female

Race: American Indian/ Alaska Native Asian Black/African American Hispanic or Latino? Yes No
 Native Hawaiian/Pacific Islander White Unknown Other (Specify) _____

MEDICAL SCREENING:

1. Do you have a serious reaction, such as difficulty breathing, to eggs or a flu vaccine?..... Yes No
 2. Have you ever had any form of asthma?..... Yes No
 3. Have you ever developed Guillain-Barre Syndrome within six weeks of getting an influenza vaccine?..... Yes No
 4. Are you pregnant?..... Yes No
 5. Do you have a long term health problem (heart, kidney, lung, liver disease, diabetes, blood disorder)? Yes No
 6. If under 18, are you currently receiving aspirin or aspirin-containing therapy? Yes No
 7. Do you have AIDS, HIV, cancer or have you received an organ transplant?..... Yes No
 8. Have you received a vaccine measles, mumps, rubella, chickenpox, or Seasonal FluMist in the last month? Yes No
 9. Are you in close contact with severely immunocompromised individuals requiring a protective environment (such as bone marrow transplant recipients)? Yes No
 10. Do you have a fever?..... Yes No
11. Which dose of the H1N1 vaccine are you receiving today? Dose 1 Dose 2 Date Dose 1 given:

Consent and Request to Receive H1N1 Vaccination (please check box if agreed)

- I have read the information recorded above and certify that it is correct.
- I have received a copy of the Centers for Disease Control and Prevention (CDC) 2009 H1N1 Influenza Vaccine Information Statement (VIS) dated 10/2/2009 and have read or had explained to me the information in the VIS.
- I have had an opportunity to ask questions about the 2009 H1N1 Influenza vaccine and they were answered to my satisfaction.
- I have received or been offered a copy of the Notice of Privacy Practices.
- I understand the risks and benefits of receiving the 2009 H1N1 Influenza vaccination and hereby give my consent to having the 2009 H1N1 Influenza vaccination administered to me or to the person named above for whom I am authorized to consent.

Signature

Printed Name

Date

For Clinic Use Only

Clinic Date: _____ Date VIS given: _____ Administration site: Intranasal (Mist)

Affix Label (Manufacturer, Lot #, Expiration Date, Vaccinator Initials) Here